Babajide Folarin Ademujimi

Aldyn Care Home

Inspection report

25-27 Canada Grove
Bognor Regis
West Sussex
PO21 1DW

Tel: 01243820580

Date of inspection visit:
29 March 2018
03 April 2018

Date of publication:
30 May 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 29 March and 2 April 2018 and was unannounced on the first day.

Aldyn Care Home is a residential home providing care, rehabilitation and support for up to 12 people with mental health needs. At the time of the inspection, 11 people were living at the service. Some people might be detained under the Mental Health Act and may be under supervision in the community.

At the last inspection, the service was rated Requires Improvement.

At this inspection we found the service remained Requires Improvement.

Why the service is rated Requires Improvement.

The service had a registered manager in post. This person was also the registered provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The previous inspection in January 2017 found concerns that staff had not received training to keep people safe and systems were not robust to safeguard people. The previous inspection also identified staff had not received mental health training and regular supervision. The provider sent us an action plan following this inspection. We found these areas had improved, however we found concerns in other areas at this inspection.

Staff knew people well and knew their risks but risk assessments and care plans did not accurately reflect people's current risks or have sufficient detail to guide staff on what action they should take to keep people safe. We also found one accessible upstairs window at the service posed a potential risk if people wished to self-harm.

Staffing levels were adequate to support people who were largely independent and required emotional support. However, the staff duty rota was not an accurate reflection of the staff on duty at the time of the inspection.

People were not always supported by staff that confidently made use of their knowledge of the Mental Capacity Act (2005), to make sure people were involved in decisions about their care and their human and legal rights were respected. The service did not always follow the processes which were in place to protect people's human rights and liberty.

There were some quality assurance systems in place but these required improving. The management team

were not up to date with current mental health policy and practice. People's opportunities for recovery were limited by this. Inspection feedback was listened to and the registered manager and deputy keen to make changes and improvements to enhance care.

Staff responded quickly when they noted changes to people's mental or physical well-being, contacting the appropriate health professionals, for example people's named mental health nurses. People or where appropriate those who mattered to them, were involved in discussing people's care needs and how they would like to be supported. People's preferences for care and treatment were identified and respected.

Staff exhibited a kind and compassionate attitude towards people. Positive, caring relationships had been developed but aspects of people's care was not always person focused. Staff had appreciation of how to respect people's individual needs around their privacy and dignity.

People had their medicines managed safely. People received their medicines as prescribed, received them on time and understood what they were for. People were supported to maintain good health through regular access to health and social care professionals, such as GPs, mental health nurses and social workers.

People told us they felt safe. The environment was uncluttered and clear for people to move freely around the home. Most staff had undertaken training on safeguarding vulnerable adults from abuse, they displayed good knowledge on how to report any concerns and described what action they would take to protect people against harm.

People were supported by a staff team that had received a comprehensive induction programme, training for mental health conditions and ongoing support from the registered manager and deputy manager.

People were protected by the service's safe recruitment practices. Staff underwent the necessary checks which determined they were suitable to work with vulnerable adults, before they started their employment.

The service had a policy and procedure in place for dealing with any concerns or complaints.
No written complaints had been made to the service in the past twelve months.

People and described the management to be supportive and approachable. Staff talked positively about their jobs. The deputy manager was supported by the registered manager / provider. Both were visible at the service and well known.

We found three breaches of our regulations.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service remains Requires Improvement

The service was not consistently safe.

People's risks were not always well managed, clear and documented.

People were cared for by sufficient staff but duty rotas were not clear.

People received their medicine safely, however "as required" medicine protocols could be further personalised.

People were cared for in a clean service; however infection control policies and procedures required further embedding.

Is the service effective?

Requires Improvement

The service remains Requires Improvement.

It was not always clear that people had consented to their care and treatment or that staff had a good understanding of the Mental Capacity Act.

People enjoyed the food at Aldyn however meal choice and times required improvement.

People achieved good outcomes at Aldyn Care Home.

People were supported by staff who had received training to meet their needs.

Is the service caring?

Requires Improvement

People were supported by caring staff but there were area for improvement.

People were not always involved with care and treatment decisions.

People's care was not always person-centred.

People's independence was hindered by practices at the service which were risk adverse and could be seen as controlling.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The responsiveness of the service requires improvement.

People's care plans were not always reflective of their individual needs.

People's end of life needs had not been considered.

People's concerns and complaints were listened to.

People were encouraged to follow their interests.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems and processes in place required development to reflect current standards of mental health care, regulation and best practice.

The culture was not always person-centred and empowering for people living at Aldyn Care Home.

Responsibilities within the management team were clear.

People told us the management team were approachable and listened to them.

The management team listened to inspection feedback and were keen to improve.

Aldyn Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was unannounced and undertaken by two adult social care inspectors and an expert by experience on the first day and one adult social care inspector on the second day. The inspection took place on the 29 March and 2 April 2018.

Before the inspection, we reviewed information we held about the service. This included previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

Prior to the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. Due to technical issues this was not received.

During the inspection we spoke with the deputy manager and registered manager / provider. We spoke with two staff on duty and seven people who used the service.
We looked at five records related to people's individual care needs and discussed the care and support other people at the service received. These included support plans and risk assessments. We also looked at records related to the administration of medicine, training records and discussed staff recruitment processes with the registered manager. We reviewed the quality assurances processes in place at the service and feedback people had provided.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection in January 2017 we found people were not always protected from abuse because staff did not have a good understanding of safeguarding. The provider sent us an action plan which advised staff training on keeping people safe would be put in place. We found that most staff had received safeguarding training and understood how to protect people from harm at Aldyn Care Home and within the local community. We discussed with the registered provider and deputy manager the importance of all staff, including domestic staff attending this training. They told us they would arrange this.

People told us they felt safe at Aldyn Care Home, however we found improvement was required in to the assessment of risk in relation to people's health needs, the staff rota, aspects of safety at Aldyn and medicine management.

People were supported by staff that understood and managed risk effectively but records reflecting risk management approaches required improvement. Risk management plans were limited and not always an accurate reflection of people's current risk. Assessment tools such as nutritional screening tools, skin care assessment tools and choking risk assessments were not in place where needed to help identify risk. For example, one person had been identified as having a poor appetite, being at risk of choking and required pressure relieving equipment to help prevent skin damage. Although staff had acted to keep them safe from harm (we were told this information was now out of date as they had improved), they had no risk assessments in place demonstrating the risk had lessened. Another person had a significant past history of fire setting when unwell but their risk assessment had not identified any risk despite this person having set fire to a mattress at the service previously. Where risks were identified, for example if people were at risk to others or at risk of self-neglect or self-harm, there was little specific information in the care plans to guide staff how to keep them safe. Where people had physical health needs, for example due to diabetes, greater information was required to guide staff on what action they should take if the person had high or low blood sugars. We fed this back to the management team who agreed to update care plans and risk assessments.

Where people had been identified at risk of falling, there were not robust risk assessments in place to address this. For example, one person had the ability to decide they wanted an upstairs room but their care records identified there was a risk of them falling on the staircase. There was no plan in place to mitigate the potential risk. We found further detail was also required where people and / or staff were at risk due to behaviours people presented with, for example verbal and / or physical aggression.

We found that not all areas of the home were safe and secure. For example, an upstairs bathroom window opened fully and did not have restrictors in place. We raised this as a concern with the management team due to the nature of people they were caring for who had the potential to self-harm if unwell. We also spoke to the registered manager about risk assessing potential ligature points within the home which might have the potential to harm. They agreed to action this following the inspection.

Staff ensured the environment was as safe as possible in the event of a fire. For example, many people smoked and despite being strongly discouraged by staff, some continued to smoke in their bedrooms.

Furnishings were fire retardant and regular fire checks were conducted. However, there were no personal evacuation plans at the service. These are used to identify the support people might require in the event of a fire at the service. The service did have people with limited eyesight and mobility issues, evacuation plans identifying people's individual needs would support safe evacuation of these people. Maybe add that staff had the knowledge if not under a breach We fed this back to the management team.

Care and treatment was not always provided in a safe way. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe, "Yes, I do. They fully protect me from the elements" and they had no concerns about staffing numbers. The provider, who was also the registered manager, regularly reviewed the staffing levels, so that people received reliable and consistent care, and to help ensure staff could be flexible around people's needs, appointments and activities. Additional "bank" staff were used in the event of sickness or staff holiday. However, the staff rota did not accurately reflect the staff on duty. For example, some staff were working during the inspection that were not on the rota, and other staff were not working who were due to work according to the staff rota. This meant it was difficult to know who was meant to be on duty that week and in the event this information was required in the future, it would be hard to know which staff had worked and what hours. We spoke to the management team about this who advised a daily handover was done and noted which staff were working on the day but they acknowledged the rota recording required improvement.

Medicines were administered consistently and safely. People told us, "You have medication on time, yes, after breakfast, dinner and supper"; "Yes, on time. 8 o'clock at night or just after" and "I take my medication on time". No one was on medication without their knowledge (covert). Staff were appropriately trained and confirmed they understood the importance of safe administration and management of medicines. We looked at medicines administration records (MAR) and, we noted all had been correctly completed. The service had a clear medicines policy, which stated what staff could and could not do in relation to administering medicines. The management team and staff confirmed they had a good relationship with their local pharmacy for any advice or support they required. Staff knew those people who were on medicines which required special monitoring and knew potential side effects to be aware of. Protocols were in place for "as required" medicines but these required greater detail to ensure consistency and guide staff. However, the deputy manager informed us if PRN (as required) medicines were to be used; staff always sought advice or called the "on call" staff on duty to discuss.

People were supported by suitable staff. Robust recruitment practices were in place and the registered manager advised checks were undertaken to help ensure the right staff were employed to keep people safe. Staff confirmed these checks had been applied for and obtained prior to commencing their employment with the service.

All areas of the home were clean. A domestic was appointed to clean the home, although people were encouraged to keep their own rooms clean, staff supported them when they found this difficult. We spoke with the provider about ensuring best practice recommendations were followed in relation to laundry processes and wearing of personal protective clothing and ensuring cleaning products were kept safe.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection in January 2017, we found that staff had not received training and supervision. The provider sent us an action plan and we found at this inspection staff had received mental health training and were receiving regular one to one supervision sessions to discuss their needs and practice. However, we found consent and people's right to make unwise choices was not well understood. Aspects of care were rigid and not person-centred.

People were supported by staff who met their health and social care needs. The provider had an essential training programme which staff were required to complete. Additional training was provided by the management team for staff to enable them to support people's complex mental health needs. Following the last inspection in January 2017, most staff had undertaken a three day course including updates on first aid, moving and handling, equality and diversity, medicine awareness, food hygiene and safeguarding. The registered manager and deputy manager closely monitored staff training to ensure it remained in date.

Staff received a thorough induction programme, which included shadowing experienced staff when they started with the provider. The registered manager monitored staff progress through regular supervision and one to one meetings to ensure they were confident in their role. Newly appointed staff where necessary, completed the new care certificate recommended following the 'Cavendish Review'. The outcome of the review was to improve consistency in the sector specific training health care assistants and support workers received in social care settings.

Formal and informal supervision took place to support good practice and support staff. The registered manager observed care and interactions regularly and was quick to discuss any shortfalls with staff promptly.

Most people had capacity to make their own decisions at Aldyn Care Home. Staff involved people in most of their care decisions. When people's mental health deteriorated and affected their capacity to make decisions staff contacted health care professionals in order for an assessment under the Mental Capacity Act or Mental Health Act 1983.

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

Had staff had received some training in MCA but displayed little understanding of the requirements of the act, and it was not being followed in practice. For example, some people did not have the ability to make decisions about their finances but there were no recorded mental capacity assessments to reflect these decisions. Some people also had support to manage their cigarettes but the documentation was lacking to evidence they had consented to these plans or did not have the ability to manage their own cigarettes.

Staff we spoke with were very uncertain about the Mental Capacity Act and this meant there were practices at the service which could be seen as restrictive and unnecessarily controlling. For example, in relation to people's drinks there were set times for hot drinks. We observed people queuing up in the mornings to get a hot drink. Some staff told us these set times were because people "filled themselves up" on drinks and then didn't eat well; others told us people had chosen these times in a meeting some time ago. There was a small area near the dining room where people gathered and we asked the deputy manager whether people could have a kettle in this area to make drinks as the kitchen was very small. We were told people were at risk of having drinks thrown at them and at risk of scalding. However, people all went out in the local area for coffee and there were no individual risk assessments in place to identify these potential risks. Other staff spoke to us about restricting "unhealthy" foods for people who were overweight. Whilst staff did this with the best intentions, we spoke to the registered manager and deputy about people with capacity having the right to make unwise choices.

Care was not always person-centred and based around people's individual needs. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).
The management team understood the processes they were required to follow if needed. No one had a DoLS authorisation at Aldyn Care Home.

People where appropriate, were supported to have sufficient amounts to eat and drink. People were complimentary about the food and told us, "If you don't like anything for dinner – they'll cook you something else"; "They won't give you something you do not like. They'll give you something else" and, "Yes. I like the food here." Some people shared that meals and foods were not very flexible, "If you miss breakfast – you miss it. That's the policy"; '3 meals. Coffee in the morning and cup of tea at 3 in the afternoon and we get squash. They would not give you food if you miss it" and "We only get ice-cream on a Sunday".

Three people told us there were choices available if they asked and if they didn't like the main meal, although we did not see choices being pro-actively offered. The kitchen was very small which meant when staff were cooking, people were discouraged from coming into the communal kitchen for safety reasons. There were set breakfast, lunch and evening meal times and people told us if they missed the 7am breakfast they would go hungry until lunch. Some staff confirmed this; however, the registered manager said if people wanted a later breakfast they could have this. Dinner time was at 5pm. We raised concerns that there was a large gap between dinner at 5pm and breakfast at 7am. The registered manager told us if people wanted a snack they could ask but most supplemented their diet with locally bought food. Other staff told us there were not evening snacks. We discussed during feedback a more relaxed, person-centred approach to mealtimes.

We spoke with the deputy manager about how people were supported to maintain their physical health alongside their mental well-being. They told us if people wanted, they would help them seek support with smoking cessation and one person had given up cigarettes. We discussed with the deputy manager other ways people's physical health might be enhanced, for example through diet and exercise. These were areas for future development.

Staff worked together with external agencies to deliver effective care. Records showed how staff either made a referral or advised people to seek relevant healthcare services when changes to health or wellbeing had been identified. Care records evidenced where health and social care professionals had been contacted.

People told us they had seen their doctor when physically unwell and people told us they had contact with mental health nurses. The service supported people to attend appointments if this was required, but as part of people's recovery they were encouraged, if possible, to attend independently. One person told us, "They help me with appointments to the doctor and take me for blood test appointments." Many people who lived at Aldyn had done so for many, many years and their mental health had remained stable and they had avoided hospital admissions. One person we met had arrived very unwell physically and in a short space of time had made great improvements. Other people confirmed, "Yes. I see doctor, have my blood test, and my eyes tested. When you are not well, they would ring and tell them"; "Yes. I went to a dentist and go every 6 months' and, "I go to see my GP."

Aldyn was not purpose built. The environment was well maintained and people enjoyed a communal lounge and dining area and a further room to relax. The garden was enjoyed by people at the home and we noted some household rubbish was due to be removed from the exterior garden. We were told people enjoyed this space and were planting the pots in the summer.

Requires Improvement

Is the service caring?

Our findings

Staff were kind and caring to people but a lack of understanding about developing care alongside people meant there were areas for improvement. This would support people to make choices and decisions about their care and treatment and their routines.

People were well cared for by staff that had a caring attitude and treated them with kindness. People told us, "We are treated with kindness."

Equality and diversity was partly understood and people's strengths and abilities valued but practices at the service meant people's independence and skills could be hindered. People who lived at Aldyn Care Home had a variety of different backgrounds, experiences and health needs. People told us staff worked with them in a non-judgmental manner, with respect and with great understanding of their complexities.

Staff had genuine concern for people's wellbeing. However, the lack of staff understanding about person-centred care and recovery approaches meant people's outcomes could be limited. Risk adverse practices affected people achieving their full potential.

Staff commented that they cared about the support they gave, and explained the importance of adopting a caring approach and making people feel they mattered. Staff spoke of people with fondness, wanting them to receive good care like one of their family members. Many people had lived at the service for a long time. People new to the service had done well because of the nurturing approach of staff.

People's independence was valued and encouraged but there were missed opportunities to develop people's skills further. Staff encouraged people to develop and maintain skills to enhance their abilities to self-care. For example, some people did their own tidying of their bedroom; others enjoyed household jobs such as cleaning. This helped people's daily routine and structure, and increased their confidence and self-esteem.

Staff took time to get to know people by reading their care records, talking to their family, health and social care professionals and discussing people with the team. Therapeutic relationships with people were fostered because staff invested time in people. They nurtured and paid attention to people so they were cared for. Staff knew people's particular mannerisms which might mean they were distressed, anxious or unwell because they knew them. They took prompt action to address what might be causing someone's anxiety, for example by providing one to one time with people.

People's privacy and dignity were respected; people were encouraged to be as independent as possible. People told us staff knocked on their doors and their privacy was respected.

People were proactively supported to express their views as far as possible. Staff gave people time, and were skilled at giving people explanations and the information they needed to make decisions. Once decisions had been made, staff acted upon them to help ensure people's views were listened too and respected.

Advocacy support services were available for people if needed, for example when considering moving on to different services. Staff at the service also advocated for people ensuring their views and wishes were listened to.

Staff understood accessible ways to communicate with people. For example, one person who was registered blind, received their bank statements in braille. Communications with the benefits department was followed through with a CD disc for them to listen to which helped explain discussions. Supporting people in this way helped reduce communication barriers.

Requires Improvement

Is the service responsive?

Our findings

The service was not always responsive.

Each person had a care plan that reflected their needs but these gave limited information or guidance to staff on how to make sure personalised care was provided. We found care plans could be further personalised to reflect staff knowledge of people and discussed this with the management team. However, the staff team were small and consistent and knew people's preferences. For example, staff knew who liked cereal with hot milk and who didn't like egg sandwiches. Preferences were respected regarding what time people liked to wake and rest although people were encouraged to sleep at night to help them maintain good sleep hygiene.

People's changes in care needs were identified promptly and with the involvement of the individual, family and professionals as required. However, care plans were not always reviewed promptly to reflect changes. For example, we were told one person's needs had significantly changed as their health had improved but this was not reflected in their care plan. They had a "post it" note saying their mental had gone downhill and their personal hygiene but these had no dates on them and their care plan still reflected how they were when they were first admitted to the service. Another person's care plan (who was not very well), lacked information about how staff should support them and what action they should take in a crisis situation. Staff told us they were meeting with them twice daily to offer space for them to talk and reduce their anxiety but these important pieces of information were absent from their care records. Another person was registered blind but their care plan gave little information about how staff supported them to meet their needs. Regular staff handovers and staff discussions shared important changes to people's care and discussions from keyworker sessions. This meant staff knew what had changed and how to support people as they required. Staff were also able to tell us in detail about people's needs and how they met them.

Care records did not fully reflect people's physical, mental, emotional or social needs. They were not an accurate reflection of people's care. This is a breach of Regulation 17 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

People received consistent personalised care, treatment and support despite poor recording in care plans. Once the service agreed to support a person, an initial assessment took place. Staff made every effort to empower the person to be actively involved in the whole process. Evidence was gathered about the person's medical history and life. People were supported to move to Aldyn Care home at a pace which was right for them. We saw that when emergency assessments had been undertaken the management team had sought further information to ensure they knew people's needs. The assessments we reviewed were comprehensive.

People were protected from the risk of social isolation and staff recognised the importance of companionship and keeping relationships with those who mattered to them. People told us, "We get access to this room, videos and everything. We go shopping, to the bank when we want to. We can go to places. We don't go on coach trips because sea side is here. We can go on the bus, train or whatever"; "We go to a day

centre on Wednesday and Friday – twice a week. When the weather is fine I'd probably go to the beach – fresh air" and, "We go into the day centre and Salvation Army" and, "I know how to take a walk to the sea side and take a breath of fresh air."

People were supported to see their family and some had made friendships in the service. People were encouraged to maintain hobbies and interests but many people had symptoms which meant they lacked motivation to see plans through. A variety of in house activities were held but some people were content with going out for coffee or relaxing in the communal areas or their room. We discussed with staff considering new ideas for people depending upon their interests as many people attended a locally run day centre for companionship and staff told us people didn't always engage in the groups offered at the day centre.

People and health professionals where possible, were involved in planning their ongoing care and making regular daily decisions about how their needs were met. Staff told us how they discussed ideas about what would make a positive difference in people's daily lives and supported them to achieve their aims. For example, staff had noted when people needed more structure or activity in their lives and encouraged people to try new things. This was often difficult for people due to their mental health needs and many lacked motivation to see plans through. This information about people's interests, goals and aspirations required improving to demonstrate the service was providing responsive care.

We spoke with the deputy manager and registered manager about developing end of life care plans. Although many people were in the middle of their life, for some people this had been their home for a long time and they were ageing. The management team advised they were a residential home so would not provide end of life care. However, following further discussion about how people's needs might rapidly change and with support from local nursing services, they agreed this was an area for further consideration.

The service had a policy and procedure in place for dealing with any concerns or complaints. The management team told us they would listen and act on concerns and these would be used for learning. They told us that people had key worker sessions where they could raise concerns with staff they knew well. People's behaviour was monitored through observation for any changes which might mean they had concerns. People told us they would feel comfortable talking to staff about any complaints. No complaints had been received by the service in the past 12 months. People told us, "Yes, you can complain to them"; "I have no complaints"; "I know how to complain. If there was anything I would, but there isn't. Things would improve' and, "Yes. I just go to the staff and they help me. They always ask about how I am."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in January 2017, this area was rated as Good with Requires Improvement overall due to two breaches of regulations. At this inspection, we also found breaches of regulations and have rated well-led as Requires Improvement.

The values and vision at Aldyn Care home required improving to be more person centred and individualised. Although staff were kind and caring, the service had remained static and had not changed with policy, developments in mental health care or regulation. The registered manager / provider told us, "We run like a family unit; look after clients that are long term and take the stress out of their day to day lives." The deputy manager recognised, "We're in a bottle" meaning they were isolating themselves from best practice.

Quality assurance systems and governance processes required enhancing to ensure all regulations were met. Although the last inspection breaches had been met, a clear plan of ongoing service development was required to ensure standards were maintained. At this inspection we found the systems and processes in place had not identified risk management processes were not robust and care plans were not individualised. This meant people were at risk of unsafe care. The service wasn't organised around people's needs and choices. Some practices were institutionalised, for example set meal times and diet and cigarette management without clear, personalised plans in place.

Systems and processes required development to ensure compliance with the regulations. Records were not always accurate and contemporaneous. This is a breach of Regulation 17 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

The registered manager and deputy were both open to ideas for improvement and keen to keep up to date with changing practice. This would help drive continuous improvement within the service.

The registered manager (who was also the provider) and deputy manager took an active role within the running of the home and had good knowledge of the staff and the people who used the service. The registered manager told us due to personal circumstances they had not been as visible in the past few years. People living at Aldyn told us they thought the service was well run and the leadership good.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are "registered persons". Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were clear lines of responsibility and accountability within the management structure. The service had notified the Care Quality Commission (CQC) of significant events which had occurred in line with their legal obligations. Tasks were shared out between the registered manager and deputy manager so each knew their areas of responsibility, for example the provider ensured the maintenance and service checks were done and the deputy manager monitored the training.

Staff felt supported, listened too and felt the management was visible within the home on a daily basis. Staff told us they were happy in their work, were motivated by the management team and understood what was expected of them. Some staff had worked for the organisation for many years, staff turnover was low and staff felt valued by the on-going training and development opportunities. Supervision and appraisals were up to date for all staff.

People, relatives and professionals views and feedback on the service was sought to encourage improvement within the home. The provider encouraged people to voice their opinion and they felt listened to when they did. Questionnaires were completed by people living at the service and any responses of concern followed up and staff informed of people's feedback during staff meetings.

Staff meetings and staff handovers were held to provide an opportunity for open communication, to discuss people living at the home and any changes in need.

The provider promoted an open culture. The registered manager informed us the philosophy of the home was to treat people as individuals and respect individuality. They felt good communication and being clear with staff about expectations enabled the service to run smoothly. Staff told us "The culture is positive, genuinely caring." The home had an up to date whistle-blowers policy and defined how staff that raised concerns would be protected. Staff confirmed they felt protected and were encouraged to raise concerns. They informed us the management was visible and dealt with any issues quickly.

Resident meetings were held to keep people up to date with changes at the service, for example decorating plans and consideration of people's ideas for the menu, garden and special events such as Christmas plans.

Audits were carried out in line with policies and procedures for example there were medicine checks, cleaning checks, audits of people's money, maintenance checks. The provider received an alert when checks were due for example fire safety and health and safety checks.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (a) (b) (c) There was a lack of collaborative care and decision making. Service user preferences were not always taken into account. Service users were not always fully involved in decision making.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Care and treatment was not always provided in a safe way. Risks to service users were not always assessed and mitigated. Parts of the premises were not safe.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) Systems and processes required development to ensure compliance with the regulations. Records were not always accurate and contemporaneous.

Care records did not fully reflect people's physical, mental, emotional or social needs. They were not an accurate reflection of people's care.